Name:
DOB:
Chart:
Age:
Date:

WEST TENNESSEE BONE & JOINT
"Keeping You Active"

PATIENT INFORMATION

(Please Print)

Date:	Patient or Parent email:
Patient Name:	Patient Social Security #: Sex:
Address:	Patient Date of Birth: Age:
City: State: Zip:	Patient Employer:
Home Phone:	Employer Address:
Cell Phone:	City: State: Zip:
Work Phone:	Occupation:
Marital Status: Single Married Divorced Widowed	Spouse's Employer:
Spouse Name:	Employer Address:
Spouse Social Security #:	City: Stip:
Spouse's Date of Birth:	Employer Phone:

REASON FOR TODAY'S VISIT

Was this an Injury?	Date of Injury or Onset	Work Related?	Sports Related Injury? If yes, School Name/Phone
☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No

Describe How Injury Happened:

****Work Related Injuries Require Prior Approval****

GUARANTOR INFORMATION

(Person responsible for the Account if Other Than Patient)

Name:	Relationship to Patient:
Address:	Date of Birth:
City: State: Zip:	Social Security Number:
Employer:	Home Phone:
Employer Address:	Work Phone:
City: State: Zip:	Does Patient live with Guarantor? Y N (circle)

PHYSICIAN AND INSURANCE INFORMATION

Primary Care Physician or Referring Physician:

Primary Insurance Co:	Policy #: Group #:
Policy Holder Name:	Social Security #:
Relationship to Patient:	Date of Birth:
Co-Pay Amount (if applicable):	Employer:
Secondary Insurance Co:	Policy #: Group #:
Policy Holder Name:	Social Security #:
Relationship to Patient:	Date of Birth:
Co-Pay Amount (if applicable):	Employer:

Name:
DOB:
Chart:
Age:
Date:

ALTERNATE OR EMERGENCY CONTACT INFORMATION	
Name:	Home Phone:
Address:	Cell Phone:
City: State: Zip:	Relationship to Patient:

Preferred Pharmacy Name: _____ Phone: _____					
Address:					
Patient Demographics					
Race:	□ American Indian	□ Asian	□ Black	□ White	□ Other:
Ethnicity:	□ Non-Hispanic	□ Hispanic		□ Other:	
Language:	□ English	□ Spanish	□ Chinese	□ Japanese	□ Portuguese

Consent for Medical Treatment

I authorize West Tennessee Bone & Joint Clinic physicians and personnel to render medical treatment and evaluation needed. I further authorize order of x-rays, injections, casting or other diagnostic tests and treatment that may be necessary.

Consent for Release of Medical Information

I understand that I have rights regarding my protected health information. These rights are governed by the Health Insurance Portability and Accountability Act of 1996. (HIPAA) I have been informed, and given the opportunity to review and secure a copy of the Clinic's Notic of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information.

I hereby authorize the release and disclosure of my protected health information for treatment or payment for health care operations. I understand that any and all records concerning my personal and medical history are the confidential property of West Tennessee Bone & Joint Clinic, P.C.

I agree that West Tennessee Bone & Joint Clinic may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

I agree that by providing my email address I am giving consent for West Tennessee Bone & Joint Clinic to set me up for a patient portal account. I also agree that by providing my cell phone number I am giving consent for West Tennessee Bone & Joint Clinic to contact me b this phone number.

You may restrict the individuals or organizations to which your health care information is released and you may revoke your authorization to us at any time, however, your revocation must be in writing and delivered to our address.

Consent for Financial Responsibility

I acknowledge full financial responsibility for services rendered by West Tennessee Bone & Joint Clinic, P.C. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements are made prior to treatment. I agree to pay all collection and attorney fees, if applicable, in the event of default of payment of charges. I assign benefits to and authorize direct payment to West Tennessee Bone & Joint Clinic of which it is entitled. This also includes proceeds and benefits accruing under any settlement, structure or otherwise, or awarded in judgement for personal injuries caused by a third party for payment of services rendered by West Tennessee Bone & Joint Clinic. I agree to pay for all charges not paid pursuant to this agreement.

_____ _____

Signature of Patient or Responsible Party
(Must be 18 years of age or older to sign)

Date

If you have any questions about this form, please ask the receptionist. Bring completed forms along with photo identification and current insurance cards to the receptionist. This procedure is for your protection against abuse to your insurance.

Name:
DOB:
Chart:
Age:
Date:

WEST TENNESSEE BONE & JOINT
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ADDITIONAL CONSENT FOR DISCLOSURE OF MEDICAL INFORMATION

West Tennessee Bone & Joint Clinic, P.C. realizes you may wish to have a family member or close friend present at times when health information is discussed with you, such as the time of your office visit, prior to and after surgery, discussing test results etc.

We realize the importance of protecting your privacy. This authorization gives the above Clinic and Staff your consent to disclose personal health information about you to your family, close personal friends, or any person that you identify, as long as the information disclosed to those individuals is relevant to the involvement in your treatment, payment or healthcare operations. The above listed Clinic may notify a family member or another person who is responsible for your care of your location and general health condition.

This form also provides you with the opportunity to choose not to have your health information disclosed to individuals in your care. You must return this form if you wish to opt-out of such disclosures.

Please initial one of the following to indicate your choice regarding such disclosures:

_____ **I do not object** to my personal health information being disclosed to a family member, friend, or another individual (et al., physician, trainer, therapist, case manager) involved in my care.

_____ **I object** to my personal health information being disclosed to a family member, friend, or another individual involved in my care.

_____ _____

Signature of Patient or Guardian
(Must be 18 years of age or Older to sign)

Date

Name:
DOB:
Chart:
Age:
Date:

MEDICAL HISTORY

(Please Print)

Patient Name:	Age:	Date of Birth:
Referring Physician:	Primary Care Physician:	
Reason for seeking medical attention (chief complaint):		
Which extremity are we seeing you for? □ Right □ Left □ Both Are you right or left handed?		
Date of injury or duration of symptoms:	Work Related? □ Yes □ No	
Current occupation:	Employer:	
Have you had any diagnostic studies for this condition? □ X-rays □ MRI □ Bone Scan □ CT Scan □ Other:		
Height: Weight:	Race: □ Black □ White □ Hispanic □ Other:	

Smoking History:

□ Never smoker
□ Former Smoker
□ Smoking Status Unknown
□ Current some day smoker
□ Current everyday smoker
□ Heavy tobacco smoker
□ Light tobacco smoker

Date started: _____ _____ _____

Amount: _____ _____ _____

Do you drink alcohol? □ Yes □ No Amount: What kind?

Do you use drugs for recreational use? □ Yes □ No Amount: What kind?

Have you ever been diagnosed with any of the following?

	Yes	No		Yes	No		Yes	No
Asthma	□	□	Rheumatoid Arthritis	□	□	Osteoarthritis	□	□
Kidney Disease	□	□	Anemia	□	□	Alcoholism	□	□
Lupus	□	□	Migraines	□	□	Sickle Cell Disease	□	□
Bleeding Tendencies	□	□	Cancer	□	□	Colitis	□	□
Heart Disease	□	□	Diabetes	□	□	Stroke	□	□
Epilepsy	□	□	Goiter	□	□	Stomach Ulcers	□	□
High Blood Pressure	□	□	Lung Disease	□	□	Depression/Anxiety	□	□
Polio	□	□	Nervous System Disorder	□	□	COPD	□	□
Hepatitis	□	□	Tuberculosis	□	□	(Chronic Obstructive Pulmony Disease)		

List ORTHOPAEDIC surgeries you have had and dates:

List any other surgeries you have had and dates:

List any NON-DRUG ALLERGIES you have (ex. Latex, pollen):

List CURRENT medications you take and dosage:

List any MEDICINE ALLERGIES you have:

Has anyone in your family had any of the following health conditions?

	Father	Mother	Sibling	Child	Other
High Blood Pressure	□	□	□	□	□
Heart Disease	□	□	□	□	□
Diabetes	□	□	□	□	□
Bleeding Problems	□	□	□	□	□
Lung Disease	□	□	□	□	□
Cancer	□	□	□	□	□
what type?					
Other:	□	□	□	□	□

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Patient Signature: _____ Date: _____

Name:
DOB:
Chart:
Age:
Date:

REVIEW OF SYSTEMS & CHIEF COMPLAINT

REVIEW OF SYSTEMS

Do you currently have any issues with the following?:

Yes No **Head, Ears, Eyes**: Cataracts, glaucoma, glasses, contacts, hearing loss or ringing in your ears?

Yes No **Nose, Sinuses, Throat, and Mouth:** problems with your nose or throat or sleep apnea?

Yes No **Skin:** herpes simplex, rashes, skin infections or changes in skin color?

Yes No **Breast:** Breast cancer, benign growths, or other changes?

Yes No **Cardiovascular:** Chest pain, palpitation, lightheadedness, syncope, murmurs, hypertension, etc?

Yes No **Respiratory:** Asthma, bronchitis, chest pain, emphysema/COPD, shortness of breath, productive cough?

Yes No **Gastrointestinal:** Cirrhosis, Crohns disease, diverticulitis, hernia, reflux, vomiting, ulcers, diarrhea, constipation, etc?

Yes No **Genito-urinary:** blood in urine, frequency, urgency, incontinence, kidney stones, etc? Dialysis? Kidney transplant?

Yes No **Gynecological:** Irregular vaginal bleeding, discharge, pain, etc? Currently pregnant? If pregnant, how many months? _____

Yes No **Musculoskeletal:** Bone cancer, osteoporosis, lupus, rheumatoid arthritis, degenerative joint disease?

Yes No **Neurological/Psychiatric:** Alzheimer's, epilepsy, brain aneurysm, brain surgery, depression, multiple sclerosis, paralysis, Parkinson's, seizures, stroke, or stroke residual, etc.?

Yes No **Hematologic and Lymphatic:** bruising, anemia, bleeding gums, blood transfusion, etc.?

Yes No **Vascular:** anemia, blood clots, hemophilia, varicose veins, pulmonary embolus, sickle cell disease, etc.?

Yes No **Endocrine:** heat or cold intolerance, thyroid problems, abnormal hair growth or loss, skin changes, etc.?

Yes No **Allergic and Immunologic:** any allergic or immunologic problems?

Yes No **Constitutional:** Unexplained fever, weight loss?

If you answered Yes to any of the above, please explain:

_____

_____

CURRENT PROBLEM

Please circle all that apply:

Chief complaint: _____

Location: Neck Upper Back Lower Back
Shoulder Arm Elbow Forearm
Wrist Hand Finger Hip
Thigh Knee Lower Leg Foot

Right Left Bilateral

Quality of Pain: Intermittent Ill-defined
Constant Burning Aching
Dull Sharp Throbbing

Pain: Left 1 2 3 4 5 6 7 8 9 10
Right 1 2 3 4 5 6 7 8 9 10

Onset: Gradual Sudden without injury
Injury: _____

How long: _____ Days Weeks Months Years

Context: Improving Worsening No Change

Modify Factors:
Improved by: Rest Activity Ice/Cold Heat
Worsened by: Rest Activity Ice/Cold Heat

Associated signs or symptoms: _____

_____

_____

Prior Evaluation:
Family Doctor ER/Urgent Care
Other Orthopedic Surgeon

X-ray MRI CT Scan Bone Scan
Lab Test Nerve Test

Prior Treatment:
Over the Counter: Ibuprofen Aleve Aspirin
Tylenol Topical
Prescription Meds: Arthritis meds Narcotics
Muscle Relaxer Steroids
Physical Therapy Chiropractor Brace

How long have you tried the above prior treatment?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Patient Signature: _____ Date: _____